Division of Mental Health and Addiction
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INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION,
INDIANA DIVISION OF MENTAL HEALTH & ADDICITION YOUTH SERVICES
HOME & COMMUNITY-BASED WRAPAROUND SERVICES

PROVIDER AGREEMENT

By execution of this Agreement, the undersigned entity ("Provider") requests enrollment as a provider of services or supplies to participants in one of Indiana's Medicaid-approved Community-Based Options for Youth and Families Wraparound Services Programs. The federally-and/or State-funded Home and Community-Based Service programs (hereinafter, "HCBS") are authorized by Medicaid. As a condition of enrollment, Provider agrees:

1) To comply, on a continuing basis, with all enrollment requirements established under rules adopted by the State of Indiana Family and Social Services Administration (FSSA), Division of Mental Health and Addiction (DMHA) and the Office of Medicaid Policy and Planning (OMPP).
2) To comply with all federal and state statutes and regulations pertaining to the Medicaid DMHA Youth HCBS Program, as they may be amended from time to time.
3) To meet, on a continuing basis, the state and federal licensure, certification or other regulatory requirements for Provider's specialty as required by the DMHA Youth HCBS program rules, including all provisions of the, State of Indiana's Medicaid HCBS program, or any rule or regulation promulgated pursuant thereto.
4) To notify FSSA or its agent within ten (10) days of any change in the status of Provider's license, certification or permit to provide its services to the Medicaid members in the State of Indiana.
5) To provide Medicaid-covered HCBS services as approved by DMHA and Medicaid, and/or supplies for which federal financial participation is available for Medicaid participants pursuant to all applicable federal and state statutes and regulations.
6) In accordance with the Health Insurance Portability and Accountability Act (HIPPA), safeguard the privacy of health information for Medicaid recipients. Health information about a recipient is considered "Protected Health Information" (PHI) and includes at least the following information:
   a) participant's name, address, and social and economic circumstances;
   b) medical services provided to the participant;
   c) participant's medical data, including diagnosis and past history of disease or disability;
   d) any information received for verifying participant's income eligibility and amount of medical assistance payments;
   e) any information received in connection with the identification of legally liable third party resources.
7) To release information about Medicaid participants only to the FSSA, its agent, or a Medicaid HCBS participant's Wraparound Facilitator and only when in connection with:
   a) providing services for participants; and
   b) conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the provision of Medicaid covered services.
8) To maintain a written contract with all subcontractors; which fulfills the requirements that are appropriate to the service or activity delegated under the subcontract. No subcontract, however, terminates the legal responsibility of the provider to the agency to assure that all activities under the contract are carried out.
9) To submit claims for services rendered by the provider or employees of the provider and not submit claims for services rendered by contractors.

10) To abide by the Indiana Health Coverage Programs Provider Manual, as amended from time to time, the Medicaid HCBS Program Provider Manual (for the program(s) in which the provider has enrolled), as amended from time to time, as well as all provider bulletins and notices. Any amendments to the Indiana Health Coverage Programs Provider Manual, the Medicaid HCBS Program, as well as provider bulletins and notices communicated to Provider shall be binding upon receipt. Receipt of amendments, bulletins and notices by Provider shall be presumed when emailed to the billing Provider's current "email to" on file with FSSA, its fiscal agent, or DMHA.
11) To adhere to FSSA communication expectations, which includes:
    a) Maintain current contact information at all times with DMHA and OMPP (HP) for all avenues of contact, including but not limited to electronic mail addresses, physical mailing addresses, all telephone and fax numbers, and any other relevant avenue of communication. Contact avenues such as social media, etc., are not considered formal and therefore do not constitute substitute acceptable avenues of contact.
    b) Accept and/or respond to certified mail. It is the responsibility of the provider to keep the “mail to” address information current in the DMHA and Medicaid provider databases. If the provider refuses to accept delivery of certified mail or if mail is undeliverable due to the failure of the provider to provide accurate delivery information to the state or its agents, the provider will be guilty of a violation of this agreement.
    c) Failure of the provider to adhere to the communication expectations may be the basis of revoking provider approval status with FSSA.
12) To submit timely billing on Medicaid approved claim forms, as outlined in the Medicaid HCBS Program Provider Manual, in an amount no greater than Provider's usual and customary charge to the general public for the same service.
13) To be individually responsible and accountable for the completion, accuracy, and validity of all claims filed under the provider number issued, including claims filed by the Provider, the Provider's employees, or the Provider's agents. Provider understands that the submission of false claims, statements, and documents or the concealment of material fact may be prosecuted under the applicable Federal and/or State law.
14) To submit claim(s) for Medicaid HCBS reimbursement only after first exhausting all other sources of reimbursement as required by the Indiana Health Coverage Programs Provider Manual, bulletins, and banner pages.
15) To submit claim(s) for Medicaid HCBS reimbursement utilizing the appropriate claims forms and, codes as specified in the Medicaid HCBS Program Provider Manual, bulletins, and notices.
16) To submit claims that can be documented by Provider as being strictly for:
    a) those services and/or supplies authorized by the participant's Wraparound Facilitator;
    b) those services and/or supplies actually provided to the participant in whose name the claim is being made; and
    c) compensation that Provider is legally entitled to receive.
17) To accept payment as payment in full the amounts determined by FSSA or its fiscal agent in accordance with federal and state statutes and regulations as the appropriate payment for Medicaid HCBS covered services provided to Medicaid HCBS participants. Provider agrees not to bill any member of a family, for any additional charge for Medicaid covered HCBS services, excluding any co-payment permitted by law.
18) To refund within fifteen (15) days of receipt, to FSSA or its fiscal agent any duplicate or erroneous payment received.
19) To make repayments to FSSA or its fiscal agent or arrange to have future payments from the Medicaid or Medicaid HCBS programs withheld, within sixty (60) days of receipt of notice from FSSA or its fiscal agent that an investigation or audit has determined that an overpayment to Provider has been made, unless an appeal of the determination is pending.

20) To pay interest on overpayment in accordance with IC 12-15-13-3, IC 12-15-21-3, and IC 12-15-23-2.
21) To make full reimbursement to FSSA or its fiscal agent of any federal disallowance incurred by FSSA when such disallowance relates to payments previously made to Provider under the Medicaid or Medicaid HCBS programs.
22) To cooperate fully with federal and state officials and their agents as they conduct periodic inspections, reviews and audits.
23) To make available upon demand by federal and state officials and their agents all records and information necessary to assure the appropriateness of Medicaid or Medicaid HCBS payments made to Provider, to assure the proper administration of the Medicaid and Medicaid HCBS programs and to assure Provider's compliance with all applicable statutes and regulations. Such records and information are specified in the "Provider Requirements" Section of the Medicaid-approved HCBS documents, Provider Manual and shall include, without being limited to, the following: (405 IAC 1-5)
    a) Medical records as specified by Section 1902(a) (27) of Title XIX of the Social Security Act and any amendments thereto;
    b) records of all treatments, drugs, services and/or supplies for which vendor payments have been made, or are to be made under the Title XIX Program, including the authority for and the date of administration of such treatment, drug, services and/or supplies;
    c) any records determined by FSSA or its representative to be necessary to fully disclose and document the extent of services provided to individuals receiving assistance under the provisions of the Indiana Medicaid program;
    d) documentation in each record that will enable the FSSA or its agent to verify that each charge is due and proper;
    e) financial records maintained in the standard, specified form; and
    f) all other records as may be found necessary by the FSSA or its agent in determining compliance with any Federal or State law, rule, or regulation promulgated by the United States Department of Health and Human Services or by the FSSA.
24) To cease any conduct that FSSA or its representative deems to be abusive of the Medicaid or Medicaid Home and Community Based Services programs.
25) To promptly correct the deficiencies in Provider’s operations upon request of FSSA or its fiscal agent.
26) To file all appeal requests within the time limits listed below. Appeal requests must state facts demonstrating that:
    a) the petitioner is a person to whom the order is specifically directed;
    b) the petitioner is aggrieved or adversely affected by the order; and
    c) the petitioner is entitled to review under the law.
27) Provider must file a statement of issues within the time limits listed below, setting out in detail:
    a) the specific findings, actions, or determinations of FSSA from which Provider is appealing;
    b) with respect to each finding, action or determination, all statutes or rules supporting Provider’s contentions of error.
28) Time limits for filing an appeal and the statement of issues are as follows:
    a) The provider must file an appeal of determination that an overpayment has occurred within sixty (60) days of receipt of FSSA's determination. The statement of issues must be filed within 60 days of receipt of FSSA's determination.
    b) All appeals of actions not described in (a) must be filed within fifteen (15) days of receipt of FSSA's determination. The statement of issues must be filed within. Forty-five (45) days of receipt of FSSA's determination.

29) To cooperate with FSSA or its agent in the application of utilization controls as provided in federal and state statutes and regulations as they may be amended from time to time.
30) To comply with civil rights requirements as mandated by federal and state statutes and regulations by ensuring that no person shall on the basis of race, color, national origin, ancestry, disability, age, sex, or religion be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination in the provision of a Medicaid or Medicaid Home and Community Based Services-covered service.
31) To comply with 42 Code of Federal Regulations, part 455, subpart B pertaining to the disclosure of information concerning the ownership and control of the provider, certain business transactions, and information concerning persons convicted of crimes. Said compliance will include, but is not limited to, giving written notice to I FSSA, the State's Medicaid HCBS Provider Specialist and its fiscal agent, at least sixty (60) days before making a change in any of the following: Name (legal name, DBA name, or name as registered with the Secretary of State), address (service location, “pay to,” “mail to,”, email or home office), federal tax identification number(s), or change in the provider's direct or indirect 'ownership' interest or controlling interest. Pursuant to 42 Code of Federal Regulations, part 455.104(c), FSSA must terminate an existing provider agreement if a provider fails to disclose ownership or control information as required by federal law.
32) To furnish to FSSA or its agent, as a prerequisite to the effectiveness of this Agreement, the information and documents set out in the Provider Demographic Form attached to this Agreement, which is incorporated here by reference, and to update this information as it may be necessary.
33) That subject to item 33, this Agreement shall be effective as of the date set out in the provider notification letter.
34) If the Provider provides direct services, to provide HCBS services solely as authorized in the participant’s Plan of Care prepared by the participant’s Wraparound Facilitator and as the services are defined in the Medicaid HCBS Provider Manual and the appropriate HCBS program.
35) To provide at least 30 (thirty) days written notice to the participant and/or legal representative, the Wraparound Facilitator, and the State's HCBS staff before terminating HCBS services to a participant.
    a) If the Provider is providing direct services, prior to terminating services, the Provider shall participate in a Child/Family Team meeting to coordinate the transfer of services to a new provider. The Provider agrees to continue serving the participant until a new provider providing similar services is in place; unless written permission has been received from the State's HCBS staff authorizing the provider to cease providing services before a new provider begins to provide the service.
    b) If the Provider is providing Wraparound Facilitation, the Provider shall participate in a child/family team meeting with the new Wraparound Facilitator present. The purpose of the child/family team meeting will be to coordinate the transfer of Wraparound Facilitation services to the new Wraparound Facilitator. The Provider agrees to continue serving the participant until a new Wraparound Facilitator is serving the participant, unless written permission has been received from the State's HCBS staff authorizing the Provider to cease providing services before a new provider begins providing services.
36) To report any incidents (including suspected abuse, neglect or exploitation) to Adult Protective Services or Child Protective Services, HCBS staff and the Wraparound Facilitator within timeframes defined in the HCBS provider manual.
37) To comply with Provider Standards issued by the Division of Mental Health and Addiction (DMHA), as applicable, and as amended from time to time. These standards are binding upon receipt unless otherwise stated. Receipt will be presumed when the standards or any amendments are emailed to the Provider's current address on file with FSSA or its fiscal agent.
38) That this Agreement may be terminated as follows:
    a) By FSSA or its fiscal agent for Provider's breach of any provision of this Agreement;

b) By FSSA or its fiscal agent for Provider's termination from any FSSA, DMHA Youth Services HCBS program;
c) By FSSA or its fiscal agent due to Provider failing to respond or make remuneration in response to a DMHA or OMPP sanction due to failure on the Provider's part to adhere to HCBS program rules, standards or expectations.
d) By FSSA or its fiscal agent, or by Provider, upon 60 days written notice.

39) That this Agreement, upon execution, supersedes and replaces any provider agreement previously executed by the Provider.

THE UNDERSIGNED, BEING THE PROVIDER OR HAVING THE SPECIFIC AUTHORITY TO BIND THE PROVIDER TO THE TERMS OF THIS AGREEMENT, AND HAVING READ THIS AGREEMENT AND UNDERSTANDING IT IN ITS ENTIRETY, DOES HEREBY AGREE, ON BEHALF OF THE PROVIDER AS A BUSINESS ENTITY, TO ABIDE BY AND COMPLY WITH ALL OF THE STIPULATIONS, CONDITIONS AND TERMS SET FORTH HEREIN. THE UNDERSIGNED ACKNOWLEDGES THAT THE COMMISSION OF ANY MEDICAID RELATED OFFENSE AS SET OUT IN 42 USC 1320a-7b MAYBE PUNISHABLE BY A FINE OF UP TO $25,000 OR IMPRISONMENT OF NOT MORE THAN FIVE YEARS OR BOTH.

Provider-Authorized Signature - All Schedules

The owner or an authorized officer of the business entity must complete this section.
I certify, under penalty of law, that the information stated in the Provider Demographic Form is correct and complete to the best of my knowledge. I am aware that, should an investigation at any time indicate that the information has been falsified, I may be considered for suspension from the program and/or prosecution for Medicaid Fraud. I hereby authorize the Indiana Family and Social Services Administration to make any necessary verifications of the information provided herein, and further authorize and request each educational institution, medical/license board or organization to provide all information that may be required in connection with my application for participation in the Indiana Medicaid HCBS Program.

Provider DBA Name: _____

Tax ID: _____

Officer Name: _____ Title: _____

Signature: _____ Date: _____

Telephone Number: _____

Note: *Failure to complete this section will result in the State returning the application for incomplete information.*